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‘Money itself discriminates’:

Obstetric emergencies in the time of liberalisation

Patricia Jeffery and Roger Jeffery

Citizenship rights in India are being transformed under economic liberalisation. In this paper, we use obstetric crises to provide an entry point to explore recent changes in people’s access to health care and their understandings of their civic rights and entitlements. We draw on our research in rural Bijnor district (Uttar Pradesh) between 1982 and 2005. Over this period, the state has increasingly failed to provide a safety net of emergency obstetric care. Poor villagers seeking institutional deliveries in private facilities face either exclusion or indebtedness. Moreover, ‘consumers’ have no capacity to regulate the quality of private health care provision—but nor do the state or civil society organisations. Villagers critique the state’s failure to provide the health care that they regard as the citizen’s entitlement. Yet the health care market is accorded no greater legitimacy by its ‘customers’. Far from providing opportunities for empowerment, then, changes in health care provision serve to disempower the poor and to reduce the moral authority of both state and market.

I

Introduction

In this paper, we explore the impact of India’s economic liberalisation on people’s access to health care and their understandings of their rights and entitlements as citizens. Among other

things, economic liberalisation has entailed retrenchment of the state's contribution to providing public goods and increasing marketisation and commodification of many aspects of social and economic life. Alongside these changes, the World Bank and other proponents of liberalisation advocate individual self-regulation and personal responsibility, rather than reliance on service provision and overt regulation by the state. With respect to health care, these changes are marked by increasing privatisation of service provision and by efforts to legitimise the requirement that individuals take greater responsibility for their own health care. Prime Minister Manmohan Singh sets the tone: basic health care should be accessible to everyone, regardless of purchasing power—but it is unreasonable to expect the state apparatus to carry the entire load:

Many people talk in terms of the role of the state as providing vital entitlements; entitlements in many ways operate as dole outs. I am not saying that people are not entitled to certain basic services that the state must provide. But I believe [that] in a country as large as ours we must think of the empowerment of the people. Enabling people to help themselves to realise their vast latent development potential is far more important. So I place more emphasis on empowerment than entitlement. ... Empowerment can motivate people to take charge of their own well-being, whereas entitlement perpetuates the relationship of the government as the sole benefactor for the people, who are passive recipients (Singh 2002: 25).

Whilst he did not suggest how people would become empowered, the Prime Minister did admit that liberalisation has not generated enough resources for the provision of basic health care by the state, and that markets are not good at delivering it either. In this paper, we focus on the care that women in rural north India obtain during 'obstetric emergencies' in order to examine the implications of these inadequacies at the local level for the legitimacy of the state and other

significant social institutions, especially the market in health care. We draw on our research in Bijnor district (in western Uttar Pradesh) which has both predated and followed the 1992 reforms.

Bijnor district's northern border is the Himalayan foothills, and its western border is marked by the River Ganges. Bijnor town, the district headquarters, had a population of some 100,000 in 2001. Land in the district is fertile when irrigated and agriculture has been transformed since the introduction of Green Revolution packages since the mid-1960s. But landholdings are inequitable and generally small: most holdings are no more than 0.4-0.8 hectares, and many households own no land at all. Wheat and rice are mostly cultivated for home consumption. The main cash crop is sugarcane, grown even by some small peasant households, and the district's industrial activities are largely oriented around sugar processing. The people we describe in this paper are mainly small peasant farmers and households that are land-poor or landless, people who have been heavily engaged in the market for agricultural produce, employment, consumption goods etc. for many years. In 1982-3, we were based in two adjacent villages, Dharmnagri (a Hindu and Scheduled Caste village) and Jhakri (a Muslim village), about 5 km from Bijnor town, and we returned there several times over the following two decades for further research. Our first project concerned the social organisation of childbearing, a theme we focused on again during further research in 2003-5.¹

Maternal mortality accounts for only a minority of deaths of women in the reproductive years, yet it has an iconic status in India and elsewhere. At the global level, reducing maternal

¹ Our village data include household censuses, maternity histories for all ever-married women, in-depth focus on about forty key informant couples, and discussions ranging over birth accounts, health care, etc. Named individuals have pseudonyms and the quotations are our own translations. For more on our earlier research, see Jeffery et al. (1989).

mortality ratios by three quarters between 1990 and 2015 is one of the Millennium Development Goals, whilst the provision of ‘emergency obstetric care’ has been central in policy rhetoric in India. In most developing countries, indeed, reducing maternal mortality is considered a key task for publicly-provided health care services. At the village level, maternal mortality is always tragic for the families involved, whether for orphaned older children or because of the indebtedness generated by expenditures that ultimately proved futile. Even near-deaths become general talking points, the crucial events being mulled over and repeated, sometimes until they achieve mythic qualities. During our first research in rural Bijnor, most women we talked to had relatives—mothers, sisters, cousins—who had died in childbirth. Pregnant women often expressed acute anxieties that something might go awry during their imminent labour. In rural Bijnor, most women deliver at home. Institutional deliveries have increased, however, from under 1 per cent of the pregnancies in Dharmnagri and Jhakri in 1973-82 (4 out of 449), to almost 9 per cent (54 out of 620) in 1993-2002, a level comparable to the overall figure for rural UP of around 11 per cent (Mishra 2005: 66). Women’s accounts indicate that almost all these institutional deliveries were undertaken reluctantly. Several women would probably have died but for the care they eventually received. Notably, all but two of the institutional deliveries in the recent period involved admission to private nursing homes in Bijnor town, rather than the government hospital. In part, this is simply because private health care provision has expanded since the 1980s.

The neo-liberal discourses associated with economic liberalisation imply that new kinds of citizens will be constituted, citizens who would no longer look to the state for services and support, but who would be autonomous, self-reliant and responsible consumers. Such citizen-consumers would embrace the reforms that empower them to exercise informed choices and

participate in the marketplace, and would be energetic and entrepreneurial in shopping around, for instance, for appropriate health care (see Rose 1999). In several ways, however, this seemingly optimistic formulation masks processes that are rather less than benign. First, the central presumption of equal market power belies the systemic inequalities on the global stage (Sparke 2006). Countries in the global South are subject to the hierarchical ‘supra-national governmental regime’, but also to the ‘international regime of development’ (as embodied in the Bretton Woods institutions, for instance). Agendas generated in the global North tend to compromise the social rights of citizenship—such as access to health care—that had been established in many places in the global North but which had been scarcely met, if at all, in the global South (Hindess 2002). The playing field within India, though, is no more level than it is in the global arena. Thus, it is also vital to attend to local specificities and explore how macro-level economic reforms and the meta-narratives of neo-liberalism play out within inequitable social and economic power structures on the ground (Sparke 2006). Moreover, the filtering of the discourses of neo-liberalism through real institutions can also permit slippage between the *intentions* and the *effects* of neo-liberal reforms and may allow some space for contestation and subversion at the local level (Haney 2008).

Within India, for instance, the Uttar Pradesh (UP) government has been the recipient of two World Bank loans dating from 2000 that have affected the health sector: the Fiscal Reform and Public Sector Restructuring Programme that required a 2 per cent per annum cut in public employment, and the UP Health Systems Development Project which, amongst other things, pushes towards public-private partnerships in health care provision. Such restructuring of health care differentially affects the citizens of UP who are located in diverse structures of inequality and have highly varied experiences of the increasing marketisation of health care provision.

Undoubtedly, it poses relatively few problems for the wealthy or well connected who can pay for services rendered, and for medical practitioners who can take advantage of the new spaces for private health care and who (as providers) have the capacity to extract payment for those services. It is far from clear, however, that poor rural women and their kin can weather obstetric emergencies better than previously.² Rather, most villagers in western UP cannot be autonomous neo-liberal consumers. They are hard pressed to pay for the health care they obtain from private providers and their engagement with the health care market all too often results not in empowerment but in further indebtedness and impoverishment. In the context of widespread poverty, the state's failure to provide even the safety net of emergency obstetric care can have disastrous implications for household finances and wellbeing. Moreover, the changes associated with economic liberalisation mean that quality of provision cannot be assured: the state has little capacity to render the health care market accountable, and civil society organisations or patients and their families are neither competent nor well-placed to do this themselves (a point that also applies to other aspects of the state's activities: see Drèze and Sen 2002: 363-75). Villagers are, moreover, generally well aware of many of these issues. They mount critiques of the state's failure to provide the health care that they consider to be the citizen's entitlement. The state's increasing marginality in people's repertoire of health care options undermines its moral authority, yet they do not buy into the marketisation of health care either: the health care market is accorded no greater legitimacy by its 'customers'. Indeed, the health care market is regarded as an ambiguous saviour, at best, and villagers comment adversely that private health care provision is a 'business' and not the service it should be.

² We cannot address here the effects of gender, caste and communal politics on these issues.

II

Economic liberalisation and health care

Although the Indian government *formally* adopted a programme of structural adjustment only in 1992, state-funded biomedical health care services in UP—particularly in rural areas—were notoriously under-funded and woefully inadequate well before then. The urban bias in provision during the colonial period was not remedied by independent India’s ‘developmental’ state in the 1950s and 1960s (Jeffery 1988).³ The 1978 Alma Ata proclamation of ‘Health for All by the Year 2000’ advocated ‘comprehensive primary health care (PHC)’ to address rural health needs worldwide. But comprehensive PHC faltered almost immediately: by the early 1980s, ‘selective’ programmes (e.g. malaria control) replaced ‘comprehensive’ ones. Such ‘vertical’ programmes, however, have been widely criticised as donor-driven; as unsustainable because of reliance on external funding; as piecemeal, single-issue technical-fixes of debatable cost-effectiveness; and as detached from the regular health care system rather than embedded in social, economic and political contexts or linking public health measures to curative health care (e.g. Freedman, et al. 2005:36-45; Qadeer 2003). This general failure to provide comprehensive primary health care was true for UP (and elsewhere in India).

The roots of liberalisation can be traced to excessive lending by Northern banks flush with oil money in the mid-1970s. Many countries in the global South became seriously indebted. From the early 1980s onwards, structural adjustment programmes (SAPs) were introduced in many countries in the global South to eradicate balance of payments problems through drastic changes in economic policies. Advocates of SAPs considered that state provisions were costly

³ This section draws more generally on several of the sources cited in the text as well as on Drèze and Sen (2002: 208-213); Jesani (2003); Karlekar (2003: 117 ff).

and inefficient, so state responsibilities and budgets should be reduced, and that market competition should be encouraged. They did not see health care as a need, right or social good to be catered to by the state, and they were happy for the state sector to be residualised. Rather, they saw health care as a demand emanating from individuals, a commodity that should largely be met by the market.

Even by the early 1990s, though, reports of the detrimental and ramifying effects of SAPs (particularly on women and the poor) were coming from many places that had adopted SAPs in the 1980s (see Afshar and Dennis 1992; Commonwealth Secretariat 1989; Cornia et al. 1987 and 1988; Sparr 1994; World Development 1991; World Development 1995). In response, the World Bank retreated slightly: public sector health care would be a safety net or gap-filler offering those aspects of health care that the market could not or would not provide (the so-called ‘market failures’). The subtitle of the 1993 Development Report—*Investing in Health*—captures the continuing preference for the supposed benefits of ‘market efficiency’ and ‘customer’ satisfaction, however (World Bank 1993; see Rao 1999a for an extended critique with respect to India).

Despite the criticisms levelled at SAPs, then, liberalisation in India during the 1990s affected state health systems and their budgets (Dev and Mooij 2005; Mishra 2005; Qadeer et al. 2001a; Rao 1999a; Sen et al. 2002). During this period, the states came under an increasing financial squeeze: their allocation to health care declined substantially and there was a relative shift of state health resources away from primary health care. Central government allocations to the social sector as a whole continued to increase during the 1990s, although more slowly than in the previous decade and heavily buttressed by external funding; and the central government’s percentage share of total health sector allocations increased in comparison with the states. Thus

we have the apparently paradoxical situation that central funding in state health budgets showed a relative increase even though central funding itself declined. The overall decline in allocations to the social sector was uneven around the country, with the poorer states (already with weak social sector provision) being worst affected (Rao 1999b). UP is either the lowest or in the bottom three of larger Indian states in any comparison of the value and poverty-related public expenditures on health (Mishra 2005: 76-77). In UP, per capita public expenditure on health in 1999-2000 was only about 85 per cent (in real terms) of that in 1990-91 (Dev and Mooij 2005: 102). Declining health sector allocations disproportionately favoured urban areas and family welfare (family planning) (Mishra 2005: 76). In the social sector as a whole, staff salaries accounted for over 90 per cent of expenditures (Dev and Mooij 2005: 104-105) yet many posts remained unfilled: for instance, 82 per cent of obstetric and gynaecology posts in UP were vacant in 1992 (Sen, et al. 2002: 293). Subsequently, there were drastic cuts in investment in new clinics and hospital infrastructures and in maintenance budgets, and steep declines in staff recruitment to expand provision or simply to replace staff who retired. In poorer states such as UP, cuts in government services disproportionately affect poor people who generally rely more heavily on the state for in-patient and curative care (Baru 1998: 63, 86). The UP state sector has never flourished sufficiently to meet the health care needs of the major portion of the population. Thus, rather than heralding a sea-change, funding shortfalls to the state system during the 1990s further compromised a health care system that was already severely hobbled by inadequate funding.

Viewed from another direction, health care provision in India has always been a 'mixed economy', in which private practitioners—with various levels of training or none—provided some health care. Even in 1946, 73 per cent of allopathic doctors practised privately, although the private sector expanded from the late 1970s in particular (Baru 1998: 46). Already facing a

debt crisis in the early 1980s, the government *Statement on Health Policy* (Government of India 1982) talked of further opening up health care to non-governmental players. The private sector, though, expanded only partly because of the debt crisis and the subsequent structural adjustment liberalisation: bank nationalisation and the state sector's failure to increase provision in line with population growth created spaces into which private practitioners could move (Baru 1998: 150 ff.). By the 1990s, many commentators were remarking upon the increasing salience of private practitioners in catering to many needs that might otherwise have been provided by the state, an uneven march of privatisation and commercialisation consonant with World Bank orthodoxy. Private practitioners established clinics where they could expect a reliable income, which tended to be in more wealthy states, and urban and suburban areas (Baru 1999; Chakraborty 2002). Generally, they offered only out-patient care or in-patient care in small nursing homes. By the mid-1980s, there were high rates of utilisation, especially in the wealthier states (Baru 1999), although 80 per cent of in-patient care was still obtained in the state sector (Krishnan 1999: 209 ff.). According to NSS figures, by 1995-96 the private sector was providing over 80 per cent of out-patient care and nearly 60 per cent of in-patient care. By 2000, public expenditures on health in India were markedly lower than elsewhere, but private expenditures—at 4 per cent of GDP—greatly exceeded those in most other developing countries (Dev and Mooij 2005: 102-03). Indeed, the World Bank report entitled *India: Private Health Services for the Poor* comments: 'In the poorer states such as Bihar and Uttar Pradesh, the public sector is completely dysfunctional and there are no effective alternatives to the private sector' (Radwan et al. 2004: 13).

III

Liberalisation in local practice

The government dispensary in Dharmnagri is the locally visible face of declining state investment in health services. Established in the 1950s through the patronage of the dominant local landowner, the buildings were dilapidated and mildew-encrusted even by the early 1980s. The operating theatre was last used during the sterilisation drive in the Emergency of 1975-7 and it has remained locked ever since—apart from serving as our somewhat less than bijou residence in 1982-3. The maternal and child health clinic built during the 1980s has been used as a polling booth and a residence, but not for its intended purpose. A post-partum building constructed with World Bank funds has never been unlocked and used. Doctors posted to the dispensary prefer to live in Bijnor town rather than in their official residence on the compound, which has a leaking roof, broken windows and rotten shutters. The fabric of the other buildings is similarly ill-kempt. For several years, patients had to skirt round the boughs of a fallen tree resting on the veranda of the main clinic building. Scarcely legible advertisements about tuberculosis (TB) treatments and the virtues of family planning adorn the walls, whilst a rusty notice proclaims ‘first a latrine, then a daughter-in-law’. The open areas between the buildings contain a dense growth of weeds (mainly marijuana). Despite readily-accessible ground water, plumbing is non-existent, and a disused well and several hand-pumps are dotted around the compound. Electricity supplies to the village are erratic and the dispensary has no back-up facilities. Indeed, when we were living there in 1990-1, the power lines were disconnected by the State electricity board because the bills had not been paid for several years. There are no autoclaves and no means of ensuring a cold chain for vaccines (for UP more generally, see Drèze and Sen 2002: 201 ff.).

Even in the early 1980s, rather than seeking medical care from the government dispensary, patients from Dharmnagri and Jhakri often obtained advice and treatment for their

ailments from private practitioners. In 1982, there were three or four male practitioners at a crossroads about 1 km from Dharmnagri. Several of the government dispensary staff (illegally) offered medical care on a private basis. Going further afield was difficult, however, as the villages had very poor transport services. Thus, people mainly sought medical treatment for intractable and chronic problems (infertility, repeated miscarriages, TB, kidney stones) rather than for medical emergencies (such as obstructed labour or accidents).

By 2002, however, around a dozen independent medical practitioners—all men—were running small enterprises from roadside kiosks in the locality (see Pinto 2004 for an account of private practitioners elsewhere in rural UP; Rohde and Vishwanathan 1995). Most possess no recognised credentials in any of India's medical systems (biomedical, homeopathic, *ayurvedic* or *unani*). *Bhagats* and *maulwis* also offer treatments. Few of these local private practitioners provide in-patient care. Further, they generally prescribe biomedical remedies (often by injection) (as is common elsewhere: Sen et al. 2002: 296). In addition, access to Bijnor town is much easier nowadays and there has been a significant expansion in the numbers of non-state health practitioners, clinics and nursing homes there. In 1982, just two private nursing homes dealt with maternity cases, in addition to the dilapidated government women's hospital. By 1990, a large new government district hospital had opened on the outskirts of Bijnor town. By 2002, the town also boasted 20 nursing homes with in-patient maternity care, around 30 ultra-sound centres (probably used mainly for foetal sex-determination), other diagnostic services and countless private practitioners offering out-patient services. Most nursing homes are small-scale: 9 have fewer than 15 beds, only 2 have as many as 30, most of the remainder had 15-20, not all for maternity cases. Upper-caste urban-educated Hindu doctors dominate the private biomedical

health care sector in Bijnor town.⁴ In obstetrics and gynaecology, the doctors are all women. Married couples often run clinics and nursing homes together, providing maternity care, care related to the husband's speciality, and stores selling pharmaceuticals. Since the early 1980s, then, the number of non-state urban facilities offering inpatient care has increased substantially.

IV

Rural women, urban delivery

For several decades, high levels of maternal mortality in the global South have figured, often centrally, in global policy discourses. Various programmes have been devised to remedy the situation, although their success has been very uneven. During the late 1970s, training programmes for traditional birth attendants (TBAs, known as *dais* in north India) were favoured, whilst from 1987, programmes for 'Safe Motherhood' were being developed. At the 1994 International Conference on Population and Development in Cairo, safety in pregnancy and childbirth was encompassed by a broader concept: Reproductive Health. Maternal mortality was to be halved by the decade of 1990-2000 and halved again by 2015. Some saw the twenty-year 'Program of Action' as a new paradigm (McIntosh and Finkle 1995). Yet it had been framed within the neo-liberal agenda and critics soon suggested that the admirable aim of empowering women would be countermanded by the disempowering effects of SAPs (Petchesky 1995). Numerous reviews prepared for 'Cairo +5' indicated that achievements fell far short of the goals (e.g. Development 1999).

⁴ In Andhra Pradesh, upper castes predominated amongst private practitioners: they were mainly from landowning families that had benefited from the Green Revolution, could not invest in more land because of land ceiling legislation and diversified in various ways, including educating their children (Baru 1998: 156-58).

By the end of the 1990s, it was clear that maternal mortality ratios, far from being halved, were no longer declining. Recognising that most maternal deaths can be prevented, the Millennium Development Goals include the ambition to reduce maternal mortality by three-quarters by 2015 (i.e. to the same level as projected in the ICPD Program of Action). Current policy discourse advocates ‘essential obstetric care’ (including ‘skilled’ attendants, widely available cheap and low-tech deliveries, preferably within the ‘safe’ management of biomedical institutions), with the back-up of comprehensive (or emergency) obstetric care (operating facilities, blood for transfusion etc.) and a functioning referral system (see, for instance, Berer and Ravindran 1999; Freedman et al. 2005: especially 77-94, 132-135; Maine 1999; World Health Organisation 1999).⁵

Between 1982 and 1993, maternal mortality in India generally accounted for around 12-14 per cent of deaths of women in the reproductive ages (15-44) (Qadeer 1998). During the 1990s, overall maternal and neo-natal morbidity and mortality ratios in India at best plateaued, at worst increased (Ved and Dua 2005). In 2000, for instance, between 115,000 and 170,000 maternal deaths occurred in India—about one-quarter of all maternal deaths worldwide (Freedman et al. 2005; Freedman et al. 2004). Maternal mortality ratios in UP remain disproportionately high: they were estimated to be about 900-950 deaths per 100,000 live births in the early 1980s; they appear to have declined during the period 1987-96, but only to between 700 and 750 (Mari Bhat 2001). Such statistics imply between 35,000 and 40,000 maternal deaths in UP every year (Dasgupta 2004). Many more times that number suffer serious episodes of

⁵ The targets relate to the widely accepted claim that about 80 per cent of maternal deaths occur because of obstetric crises that neither TBA-training programmes nor increased ante-natal monitoring predict. The focus on essential and emergency obstetric care, however, echoes the technical focus of ‘vertical’ programmes and detaches maternal mortality from its socio-economic context (e.g. Qadeer 1998).

morbidity during or after pregnancy (Jain and Parasuraman 2004).

In response to criticisms of SAPs, the World Bank became a major lender for health sector activities in many places during the 1990s—but mainly in ‘vertical’ programmes. In India, within the general trend of cuts in health sector budgets, central government allocations for Maternal and Child Health (renamed Reproductive and Child Health in 1997) grew from 5 to 15 per cent of total health and family welfare allocations between 1992-3 and 2002-3 (Dev and Mooij 2005: 100). This, however, masks the prioritisation of rural family planning (whose budget doubled, and grew from 17 to 25 per cent of total expenditures), despite the publicity surrounding Reproductive and Child Health in general (Qadeer 1998). In theory, the Reproductive and Child Health programme emphasises staff training, enhanced ante-natal, intra-partum and post-natal care, ‘skilled’ attendance at deliveries, strengthened emergency obstetric care and improved primary referral facilities. Initially, the programme had ambitious (and unrealistic) aims—100 per cent of deliveries with skilled attendance and reducing maternal deaths to 100 per 100,000 live births by 2010, later adjusted to 80 per cent of deliveries with skilled attendance and a maternal mortality ratio of 200 by 2007 (Jejeebhoy and Caleb Varkey 2004: 75). More recently, the Congress-led central government has focused on creating 250,000 Accredited Social Health Activists (ASHAs) who would be integrated with existing health staff (especially ANMs or Auxiliary Nurse-Midwives) to provide ante-natal, intra-partum and post-natal care (Dhar 2005; Rajalakshmi 2005).

There is silence, however, on how adequate referral services for emergency cases will be guaranteed (Ministry of Health and Family Welfare 2005), and scant attention is paid to even monitoring the circumstances in which poor women living in rural UP—the majority of the female population of UP, let us remember—go through pregnancy and childbirth. Briefly,

despite the rhetorical commitment to emergency obstetric care, women in rural Bijnor face just two options: home deliveries or costly urban deliveries.⁶ For several years, the ANM currently posted at Dharmnagri dispensary lived on the compound and provided some in-patient care (glucose drips, episiotomies). In the mid-1990s, she shifted to Bijnor town, where villagers allege she runs a small maternity clinic in her residence, from which she refers patients to private nursing homes if necessary. (She denies these allegations. As a government employee, she should neither practise privately nor refer patients to private facilities. She does take sterilisation ‘cases’ to the government hospital, to ensure that her success in motivating family planning acceptors is recorded.) Because of duties in other villages in the locality, she is usually absent from the dispensary on several days each week. Nowadays, labouring women in Jhakri call Sabra, a trained dai resident in the village, whilst women in Dharmnagri rely on an untrained dai from another nearby village; few women have contact with either of these dais before the onset of labour, however.⁷

Round-the-clock obstetric care through the state system is thus unavailable for women in Dharmnagri and Jhakri, and few deliveries approximate to the ideals enshrined in the Reproductive and Child Health programme. By the early 2000s, around 9 out of 10 births were still taking place in labouring women’s affinal homes, attended by their female affinal kin and a dai. Aside from Sabra in Jhakri, these women would not be regarded as ‘skilled’ attendants in policy discourse (or by most villagers). Neither would most of the local male practitioners who often make domiciliary visits to administer injections of synthetic oxytocin to augment labours

⁶ Generally, pregnancy is un-medicalised. Ante-natal monitoring usually comprises anti-tetanus injections administered by the ANM at Dharmnagri dispensary (which more women opt for now than in the early 1980s); a few women have ultrasound scans at private facilities, if they fear something is amiss.

⁷ For more on Sabra, see Jeffery and Jeffery (1996: 259-73).

that women and their attendants judge to be progressing too slowly. At Rs 150-200 per injection, it seemingly provides a relatively cheap solution to an apparent obstetric impasse. Yet, between 1997 and 2002, almost 1 in 5 of the deliveries that featured labour augmentation culminated in an emergency admission to a Bijnor nursing home, the journey generally made on a buffalo cart or a borrowed tractor-trolley.⁸ Indeed, there could have been more hospital deliveries, for several women gave birth *en route* to Bijnor. In the following two accounts—one from 1982 and one from 2003—both women had obstructed labours (Rajballa because of transverse presentation, Shanti because of cephalo-pelvic disproportion). Their cases highlight the calamitous potential of the obstetric crisis.

V

*Rajballa and Rohtash*⁹

When Rohtash's father died leaving six minor sons and a daughter, his older brother usurped some of his land. Consequently, in adulthood, Rohtash owned just over 0.6 hectares, whilst his uncle's three sons each owned 2.4 hectares. When we first met Rohtash in early 1982, he was supplementing his income through daily wage labour at a small mill making unrefined sugar in the village. He was paid Rs 30 per day over the winter season of 7-8 months, which would have

⁸ We are not claiming a causal linkage between oxytocin injections and obstetric emergencies (complex deliveries requiring institutional care may be more likely candidates for injections). Nevertheless, administering oxytocin in conditions in which neither the dose nor the condition of the mother and foetus can be ascertained is contrary to international standards and is almost certainly unsafe. Between 1983 and 1987, labour augmentation was used in fewer than 15 per cent of the deliveries in Dharmnagri and Jhakri. By 2002, it was used in 48 per cent of deliveries. For more on this, see Jeffery et al. (2007); Pinto (2004: 351-53); Van Hollen (2003: 112-40).

⁹ See Jeffery et al. (1989: 39-41 and 114-118) for more on Rajballa.

yielded in the region of Rs 800 per month during the period he was employed. At other seasons, his cash income was lower and more erratic, so his annual cash income from manual labour would have been in the region of Rs 7000-7500.¹⁰

Several years earlier, an accident had left Rohtash blind in one eye and disfigured on one side of his face and no marriage offers came for him (unlike his brothers). Thus, in 1980, Rohtash bought Rajballa (along with her toddler daughter from an earlier union) from her brother for some Rs 800. She probably came from eastern UP—although no one knew for sure—and was constantly being taunted about her accent by Rohtash's brothers and their wives. By April 1982, Rajballa was heavily pregnant and her ankles were badly swollen. When she was brought to the dispensary for a check-up, the ANM did an external examination and pronounced everything normal: she merely chided Rajballa for eating so much rice that it had created the swelling. A few days later, Rajballa was having a troubled labour at home. She had already drunk warm milk to 'heat' the contractions, but to no avail, so the dispensary compounder (pharmacist) was asked to administer an injection (an important component of his illegal private practice). Rajballa began experiencing rapid and strong contractions. Rohtash's female kin roundly criticised her for making too much noise. Rohtash was even summoned at one point and he silenced her with a slap on the cheek. By midnight, the contractions had stopped, so the compounder was asked to administer another injection. Fearing that the baby was presenting transversely, Patricia asked him to examine Rajballa first. He confirmed the transverse presentation and agreed that Rajballa

¹⁰ It is notoriously difficult to assess rural incomes since they are so subject to seasonal variation. In western UP, there is scarcely any rural manual employment for some 2-3 months after the rice has been transplanted in late June, whilst demand for labour is higher from October to April when rice, sugarcane and wheat are being cultivated and harvested.

should be taken to the district government women's hospital in Bijnor town. A couple of hours of discussion ensued. Rajballa's in-laws resisted the pressures from one another to accompany her—voicing fear of the treatment that Rajballa and her attendants would receive, fear that she would die, and anxiety about the cost. Eventually, some neighbouring women agreed to accompany Rajballa. It was about 2 a.m. when we arrived. The night-duty nurses were angry at being disturbed and initially refused to do anything. Patricia insisted that Rajballa should be admitted—and one nurse (deceived by the dull lighting) commented, 'These Punjabis even want treatments at night!' Patricia pulled rank, and the doctor was called: she confirmed the transverse presentation and administered a muscle relaxant so that a caesarean could be performed later. By mid-morning a healthy son was delivered.

During Rajballa's stay in hospital, Rohtash and his relatives faced rudeness and humiliation, often in full view of other patients and their attendants, as did Rajballa herself. It was hard to persuade Rohtash's relatives to remain at her bedside to ensure that medications were administered properly and punctually and that the area around the bed was cleaned. The whole episode also proved very costly for Rohtash. He had to pay out the equivalent of around two months of his annual cash income: over Rs 1000 to cover the registration fee, blood test, blood, glucose bottles and other medicines, as well as to bribe nursing and cleaning staff to perform their duties. Rohtash was not compelled to sell land however: he borrowed money from his sister's husband, who took some of Rohtash's land as surety. And if Rajballa had died, would he have reared Rajballa's daughter alone or risked buying another wife who might mistreat the little girl? It could have been much worse, he told us later.

VI

Shanti and Satish

By 2003, Satish and Shanti had been married for over 8 years, and Shanti had had three miscarriages, two in early pregnancy and one of twins at five and a half months. Satish was the *chaukidar* (night-guard) for the largest farmer in Dharmnagri and was paid Rs 1300 per month throughout the year, with an evening meal in addition.¹¹ He had also taken 0.4 hectares of land from this farmer on a sharecropping agreement that gave him just one third of the crop. The 0.25 hectares acre of land that Satish owned was mortgaged against a loan of Rs 12,000 for earlier medical treatments, and he had still not fully repaid a loan for Rs 19,000 taken out at the time of his marriage.

During Shanti's pregnancy in 2003, she was having regular check-ups in town. A private doctor in Bijnor gave her monthly injections (each costing Rs 140) to prevent a miscarriage, and prescribed pills and tonics costing some Rs 400-500 per month. The doctor's fees for each visit were Rs 100. Shanti also had an ultrasound test (costing Rs 300) to check the baby's position. By mid-October, they had spent somewhere between Rs 4000 and Rs 5000. By mid-November, the doctor warned that the baby could not be born at home—but she did not explain why. Satish still hoped there would be no more expense—and that was why, he explained after the birth in December, an entire night and day passed with Shanti in labour at home. Eventually, Satish requisitioned a neighbour's tractor-trolley to take Shanti to town. The doctor she had consulted during pregnancy immediately referred her to another nursing home with operating facilities. Within half an hour of arrival, Mula was born by emergency caesarean. His head had become elongated during the labour—Shanti's pelvis was too narrow for a vaginal birth—and the doctor had to mould his head into shape. Satish paid Rs 500 for the anaesthetic and another Rs 12,000

¹¹ In 2003, daily wage labour rates in the village were Rs60-70, but without meals included.

later for the operation. Separately, he bought medicines costing some Rs 500 and paid around Rs 800-900 to the nursing home staff (behind the doctor's back).

The doctor prepared a card detailing the place and time of birth, which Satish showed the village *pandit* (priest) when they discussed the baby's naming ceremony (*jasthaun*). Far from an elective caesarean timed for the convenience of the mother, baby and doctor, Satish had unwittingly delayed Mula's birth until the lunar asterism (*nakshatr*) called *mul* and that, too, on a Tuesday. The *pandit* explained that this was one of the most inauspicious times possible, and they would have to perform elaborate *pujas* (rituals) to reduce the evil influences. For the naming ceremony, the *hawan* and the meal for family and neighbours cost about Rs 9,000.

The costs incurred during the pregnancy and delivery and for the *jasthaun* amounted to somewhere between Rs 25,000 and Rs 28,000. Shanti estimated that they had borrowed about Rs 20,000. Clearly, Shanti's medicalised pregnancy and the unfortunate timing of Mula's birth added substantially to their outlays. The emergency obstetric care and subsequent nursing home stay alone cost about Rs 14,000, however, equivalent to around eight times Satish's monthly pay. Shanti said that Satish sometimes teases her by saying that he has lost Rs 100,000 since his marriage—he, though, remains remarkably phlegmatic in the face of all these debts.

VII

From obstetric crisis to financial crisis

In the early 2000s, some elderly women in Dharmnagri and Jhakri commented—with scornful exaggeration—that 'all babies' are being born in hospitals now because young women these days lack *himmat* (courage, stamina). Institutional deliveries have not become normalised, however, although they are more common. Significantly, the handful of women who actively sought

admission to a nursing home at the onset of labour all lived in relatively wealthy village households. Otherwise, women's accounts indicate that nursing home admissions are sought only after a woman has been in labour for a considerable time, with one or more injection administered in the hope that she would deliver at home. Women commented, 'may God not compel anyone to see the door of a hospital' or 'without distress (*taklif*), who would go to hospital?',¹²

Financial concerns are uppermost for many households. The outlays entailed in institutional deliveries compare very unfavourably with home deliveries: the dai's fees (nowadays around Rs 400-500 depending on the baby's sex) and injection(s) (another Rs 200 or so each), together total generally less than Rs 1000. At a nursing home, medical interventions and medicines cost several thousand rupees even in cases that do not need caesarean operations, supplemented by food costs for the woman and her attendants, transport costs, and any loss of income due to disrupted household routines. Money was crucial for Rohtash and Satish, who both (it should be noted) owned small amounts of land and were by no means the poorest men in the villages. Moreover, whilst our estimations should be read with caution, the cases of Rohtash and Satish suggest that land-poor households needed to raise higher proportions of their annual incomes to fund institutional deliveries in the early 2000s than in the early 1980s. Most of the other institutional deliveries created similar financial problems for the families involved. In Dharmnagri, for instance, Udayan's daughter-in-law required an emergency caesarean to deliver twin girls in 1997. The operation cost Rs 10,000 and Rs 2000 went on other costs. The household

¹² See Singh et al. (2004) for a discussion of factors that result in late referral of obstetric emergencies in

Maharashtra (including non-recognition of obstetric problems by the labouring woman's relatives, lack of cash and of transport, fear of poor quality treatment); see also George et al. (2005).

finances were already fragile because Udayan had been unable to work for several years. Indeed, his two sons' incomes were being consumed by his medical expenses, and the younger son remained unmarried until he was nearly 30, because they could not provide a separate room for him. After the caesarean operation, they could raise the cash only by selling the young woman's dowry jewellery, using a donation from her father, and taking a loan against sugarcane sales from another man in Dharmnagri. In Jhakri, the costs for Taranam's emergency caesarean in 1998 amounted to Rs 16,000—and, fearing this could happen again, Talib asked the doctor to sterilise Taranam.¹³ As one woman commented:

Poor people don't have enough money to feed themselves completely, so from where would we be able to show ourselves to a doctor? No, *bhenna* (sister), if a poor person gets food to eat that is a big thing. Whoever has money will fulfil their desires (*shauq*). And whoever doesn't have money will kill their *shauq* [so that they no longer even want something]. The entire matter is one of money.

Few village households have enough ready cash to fund even a brief hospital stay and health insurance is not part of villagers' health care imaginaries. All payments for health care are out-of-pocket and people fear being unable to raise enough money quickly and without jeopardising household well-being. Formal bank loans take time to arrange, and require collateral (usually land), so they are unavailable to the poorest villagers. Moneylenders or pawnbrokers in Bijnor town lend quickly, but generally demand some valuables as surety and charge much higher rates of interest (nowadays Rs 10 per Rs 100 borrowed, per month). In practice, kinfolk and neighbours are the major source of loans, usually but not always interest free, or even *de facto* gifts if provided by the labouring woman's natal kin. Since Rajballa was a bought bride,

¹³ See Jeffery, et al. Forthcoming for a longer account of Talib and Taranam.

Rohtash could not draw on her kin, and was reduced to mortgaging land. More generally, the poor may fail to source enough cash from their equally poor relatives and must seek small sums from several sources: kin, employer, moneylender, sale of land, livestock or jewellery etc. As with Satish, indebtedness often pre-dates the medical emergency and he was compelled to increase his debts by borrowing several interest-bearing sums, as well as Rs 4,000 from his employer which was interest-free and would entail deductions of half his pay each month (although the following month Satish was paid nothing).

Budgeting like this is typical of the kind of lives encompassed in the term *jugar ki zindagi* (an improvised life, a ‘make-do-and-mend’ life). As one woman put it, ‘there are many ways for the poor to die’—from lack of medical treatment or from the debts incurred by having it. Yet comments such as ‘money will return but a person will not’ and ‘you won’t remember the money if your patient survives’ capture people’s willingness to make outlays to save their patient’s life.

VIII

The (il)legitimacy of state provision

Emergency obstetric care can precipitate serious financial worries, yet all but two of the institutional deliveries between 1993 and 2002 were in private urban facilities rather than the government hospital in Bijnor town. Villagers are also mindful of the care different institutions provide—and, given their commentaries on government facilities, the preference for private nursing homes is less puzzling.

In 1982, there was little choice but to take emergencies to the government hospital in Bijnor town. Even then, medical care could not be obtained without payment. As Rajballa’s case

indicates, financial concerns jostled with fears about how she and Rohtash's relatives would be treated by the government staff who were renowned for being rude, lazy and grasping. Villagers still warm to the theme. Government employees are routinely alleged to be brusque, to humiliate poor, uneducated and rural patients loudly in public, to work carelessly and be inattentive to their duties, even in an emergency; government facilities are filthy and unkempt because cleaning staff are no more diligent than their medical superiors. Villagers say that government employees have no incentive to be polite, competent or hard-working, because they receive their salary each month, even if they see no patients or if patients are dissatisfied. In-patients and out-patients alike cannot expect free medicines: government staff are said to sell them to enhance their own incomes (a widespread allegation: cf. for example, Kozel and Parker 2002). In-patients must make payments several times a day to doctors, nurses, cleaners and other staff who keep replacing one another in the duty rota. Otherwise, villagers say, nurses do not administer the correct drugs on time or check on intravenous drips, and cleaners do not clean the area around the patient's bed. This expenditure is both unpredictable and extorted. Further, government doctors refer patients to private diagnostic facilities—pathology labs, ultrasound centres etc.—and are alleged to take a cut of the fees charged to patients.¹⁴ In brief, villagers do not expect timely, competent, courteous or free treatment at government facilities. As one man put it, 'anyone who cares for their patient [ailing relative] will not take them to the government hospital'.

IX

Private practice as 'business'

¹⁴ Nandraj (1994: 1681) refers to this as 'cut-practice'.

In comparison with other states, UP is not well served by not-for-profit or NGO-run health care facilities (Mishra 2005: 78). A few villagers with chronic ailments have gone to the Jolly Grant mission hospital, which provides free treatments to poor patients. But its location on the Haridwar and Dehra Dun road, nearly 100 km from Dharmnagri and Jhakri, makes it irrelevant for medical emergencies. Over the years, some villagers have obtained admission to a Delhi hospital where members of the landlord's family are involved in the management. But treatment is costly and the distance (160 km) precludes emergency treatment. Most villagers, then, resort to locally-provided health care.

Village practitioners, however, are considered capable of dealing only with 'little illnesses' (*chhoti bimari*, *chhoti marz*). They are sometimes dismissively termed fake (*naqli*, *duplicate*) or *jhola chhap* (referring to a cloth shoulder bag, a designation with fly-by-night connotations). Villagers believe that such practitioners learn their trade merely by working as a pharmacist beside a doctor and then setting up a kiosk from which to practise. Villagers are also scathing about the skills of the village dai (Jeffery, et al. 2002; Jeffery and Jeffery 1993). The knowledge (*jankari*) and equipment (*ojar*) of village practitioners and dais alike are quite inadequate to deal with emergencies, villagers say, and compare unfavourably to those in Bijnor town. Indeed, practitioners and dais withdraw from cases 'beyond my capacity' (*meri bas ki nahin*) to avoid responsibility for mishaps, and recommend that patients are taken to town. Childbirth is no exception.

Doctors running private nursing homes generally seem to have formal biomedical qualifications, and they and their employees—nurses, compounders, sweepers and so forth—are said to speak courteously and gently to all their patients, to treat them kindly and display concern for their well-being, and to pay attention immediately if patients need something. As reported

elsewhere, payments in private facilities are higher than in state facilities (Mishra 2005: 74). According to Chakraborty (2002: Table 10.9), the charges range widely between different private institutions (from some Rs 5500 to Rs 25,000 for caesareans, for instance). Nevertheless, villagers consider the charges more predictable and less subject to extortion than in the government hospital. Many private practitioners specify their fees at the outset, although even they do not always succeed in preventing their staff from requesting additional sums of money to perform their duties.

Villagers, though, also regard the kindness of private nursing home staff as an inevitable accompaniment of running a private business: rudeness and incompetence would have an adverse effect on ‘business’ (*vyapari*, a term used for market traders, merchants etc.). Private practitioners are always mindful of their reputation, villagers say, for practitioners who treat patients badly would not be recommended to others: practitioners are interested in making money—and so will not turn away someone who can pay for treatment. When Patricia asked one woman if private doctors discriminate against different kinds of patients—low castes, Muslims, villagers—her reply was ‘money itself discriminates’, and that private practitioners do not mind what kind of patients come, provided they pay the medical charges in full. Some rural practitioners are said to accept payment in instalments—but urban private practitioners are liable to prevent patients from going home until their relatives pay the entire bill. One woman likened the private nursing home to a jail, where you silently do just what the doctor tells you for fear that you might be given some medication to cause further health problems. Sometimes, patients might be able to use contacts and recommendations (*sifarish*) to obtain a fee concession—but generally patients expect to pay the entire sum specified.

Consonant with the view of private medical care as business, some villagers claim that

private practitioners cultivate rural practitioners to whom they pay ‘commission’ when they bring patients to the nursing home. One labouring woman, for instance, wanted to go to a particular nursing home in Bijnor, but a village practitioner took her to another one—and he was reputed to have received Rs 5000 of the fees her relatives paid there. Village women also claim that the current ANM at the Dharmnagri dispensary is also rewarded with ‘commission’ when she refers labouring women to private nursing homes. In addition, private nursing homes generally have ‘stores’ (pharmacies) on the premises, and villagers say that staff insist on seeing the receipts for medicines, to ensure that they have not been bought more cheaply elsewhere.

Some villagers say that private doctors treat patients to the best of their ability according to what they understand to be medically necessary. But others allege that private doctors manipulate people’s anxieties and gullibility to persuade them to accept expensive but unnecessary diagnostic tests or treatments, for instance, pressurising people into agreeing to caesareans rather than waiting to see if a vaginal delivery is possible. Moreover, villagers realise that clear divisions between state and private health care cannot be drawn in practice. Not only do government doctors refer patients to private diagnostic services, but many themselves run private practices from clinics or from their own homes. And, tellingly, villagers commented on how the self-same curt and lazy government doctor becomes charming and diligent when consulted in a private capacity.

X

Conclusion

Our Bijnor material, then, shows how—insidiously, partially but inexorably—villagers are being confronted with processes of social change that affect the terms under which they negotiate

access to health care. In this paper, we have focused on obstetric care—but many of the points we have made apply more generally to villagers' health care seeking (with the caveat that people usually engage in more 'shopping around' for treatments for chronic ailments). Here we want to highlight some implications of these developments: first, the expansion of private medical practice when there is widespread poverty and the state fails to provide a 'safety-net'; second, the regulation of the health care market, when the state's capacity has been systematically undermined, and citizens are neither competent nor powerful enough to monitor health care provision; third, how these considerations play out in relation to the moral authority of the state.

Citing NSS data from 1986-7, Krishnan argues that there was less market demand for private medical care in UP than in other states and that the poor were more reliant than elsewhere on the state sector, despite its serious inadequacies and even though state health care was not free (Krishnan 1999). Further, evidence from around the country suggests that where state-funded health care provision is particularly poor, private practitioners enter the market on favourable terms and their charges are greater than where the state system works adequately (Sen et al. 2002: 289). In UP, the retrenchment in the state sector hits the poorest people particularly hard, because there is no effective safety net. Thus villagers have been increasingly drawn into the ambit of privately-provided biomedicine, but on terms that conjure up the spectre of distress sales of valuables, greater indebtedness, or even inability to seek health care at all. The potential slide into financial ruin is by no means unique to UP. Drawing on qualitative and quantitative data from Uttar Pradesh and Andhra Pradesh, a recent World Bank report suggests that illness is a major cause of poverty, not only because of the sick person's loss of earnings but also because of the costs of treatment, whether in public or private facilities (Peters et al. 2002). Similarly, Krishna's data from Andhra Pradesh and elsewhere show that a major reason why families fall

into poverty is the cost of emergency medical care (Krishna 2006). As Mishra puts it, ‘the rural population has no option but to rely on quacks and the fee-for-service private sector leading to sickness-triggered indebtedness’ (Mishra 2005:76).

Beyond this, the advocates of reform trumpet the supposed efficiency of market forces and the benefits of consumer choice, but this serves to legitimise the exclusion of the poor and to mask how ‘quite systematically, these reforms have been deeply unequalizing’ (Freedman et al. 2005: 96; see also 39-41, 95-97; Harriss-White 1999). The market does not guarantee equality of access to health care (Jesani 2003), but results in ‘marginalizing the poor and increasing accumulation and consumption by the rich’ (Qadeer et al. 2001b: 31; see also Sen 2001). For Petchesky, economic justice is at stake (Petchesky 2003:59-60):

[when] the market becomes the source of most services for most people; and those who cannot afford to pay (‘the most vulnerable’) are left to be protected by (often nonexistent) ‘safety nets.’ In other words, health care becomes essentially a two-tier system: a commodity for many (‘health consumers’) and a form of ‘public assistance’—or an unattainable luxury—for the rest. (Petchesky 2000: 31-32)

These processes are unlikely to be reversed in the foreseeable future because the middle classes tend to benefit from them more than they suffer. Most directly, of course, institutional deliveries in private nursing homes and other kinds of private health care provisions entail a transfer of resources from the rural areas into the pockets of (some sectors of) the urban middle classes, what Jesani terms the ‘medical business class’ (Jesani 2003: 212). The entrepreneurial citizen, then, *is* making choices—but doing so in an environment that often undermines household wellbeing and solvency, and that (in the longer run) may result in the decline of the small peasantry in particular.

Second, people's willingness to pay for health care even prior to liberalisation was read by those advocating reforms as an indication that the state health sector's failings could best be remedied by expanding the market. Certainly, state provision was not beyond criticism, but the leap of faith entailed in embracing the market was misplaced. Under liberalisation, the state's capacity to act as a safety net for the poor was compromised by budgetary cuts, but so, too, was its ability to exercise the governance and surveillance functions that the World Bank and others required of it. Perhaps the belief that the proverbial 'invisible hand' would guarantee a high quality and competitive market in health care engendered complacency amongst proponents of liberalisation (although Manmohan Singh was perhaps not so sanguine). Critics, however, consider there is scant evidence of market efficiency in the health sector—rather they emphasise the undesirable consequences of encouraging privatisation without ensuring public accountability (Freedman et al. 2005: 96-97; Mishra 2005:81; Petchesky 2003: 59; Sen 2001). Even sympathisers such as Chakraborty recognise that appropriate quality assurance mechanisms are not in place (Chakraborty 2002: 274).

We should perhaps not be surprised that monitoring the market is beyond the state's grasp, given the history of its attempts to regulate even its own employees, and that legislation to regulate the public health sector is notable for its absence (Jesani 2003: 212). On various occasions since 1947, for instance, the government has attempted to prevent its employees from engaging in private practice, only to be met by protests and the haemorrhaging of doctors into the private sector (Baru 1998: 50; Jeffery 1988: 183-86). Chakraborty also points to the considerable power of private practitioners because of their dominance of health care in contemporary India (Chakraborty 2002: 274). In rural Bijnor, private practitioners—often untrained, generally unregistered—reputedly work with no more serious restraint than the hush

money they pay to government officials. In Bijnor town, most nursing homes offering obstetric services lack facilities crucial for dealing with emergencies (such as blood, oxygen, resident anaesthetist and neo-natal resuscitation equipment or incubators), and they are by no means unusual in that (Jesani 2003: 214). Villagers' allegations that private doctors advise excessive and/or unsuitable medications or unnecessary diagnostic tests are echoed in evidence from elsewhere in India (Nandraj 1994; Parikh and Radhakrishna 2005: 7; Phadke 2001; Sen et al. 2002: 296; Sen Gupta 1999: 149-50). Caesarean rates are higher in private institutions than in government facilities (Jejeebhoy and Caleb Varkey 2004: 55; Mishra 2005: 74) and, as Pai comments, unnecessary caesarean operations may become a fad for middle class women, but unaffordable for poor and rural women who need them (Pai 2000: 2760).

The private sector's deficiencies are all the more lamentable because most of their 'customers' cannot be autonomous consumers determining their own needs: rather, patients are insufficiently informed about the requirements of good medical care or the failings of particular practitioners and they are vulnerable to 'supplier-induced demand' (Jesani 2003: 213). Patients and their relatives do not constitute a sufficiently powerful lobby to protect patients' interests. Indeed the very idea that people should regulate the health care market by 'shopping around', particularly when dealing with a medical emergency, is as unrealistic as it is inhumane. Further, at least in western UP, neither civil society organisations nor panchayat health committees have the capacity to hold the health sector to account.

Third, Freedman et al. suggest that these kinds of processes de-legitimate the state (Freedman et al. 2005: 96-97), or, as we would prefer for India, *further* de-legitimate. Time and again throughout the years we have been working in rural Bijnor, people have insisted that the state should be responsible for providing services for the populace in general, and should be just,

efficient and humanitarian in its provision, whether in relation to childbearing or schooling, policing or general development work. The *state-as-idea*, then, retains considerable legitimacy (see also Hansen 2000; Lieten 2003). But the *state-as-provider* has never lived up to these ideals. Even before the time of liberalisation, there was nothing remotely approaching full welfare provision. Few villagers think they can alter the state's functioning at the local level, but this does not silence their resentment about the absence of free services for the poor and about health care provision that serves well only the relatively wealthy or those with contacts and influence. They hold the state health provision in low estimation and see it as a fine exemplar of the woeful faults that riddle government services in general. For many years, too, the state's legitimacy has also been undercut by the coercive dimensions of the *state-as-regulator*. Villagers mistrust the state and are wary of its intrusion into their lives. For instance, villagers' views of family planning have been coloured by the coercive practices that abounded during the Emergency of 1975-7; through most of the period since, incentives to staff have continued to encourage robust efforts to motivate villagers to become family planning 'cases'. Similarly, the current repeated rounds of the 'Pulse Polio' programme have put pressures on staff to achieve immunisation targets that have resulted in forceful responses to villagers' resistance (Coutinho et al. 2000; Drèze and Sen 2002: 208-13; Jeffery and Jeffery 2006: 108 ff.; Jeffery et al. 1989: 200 ff.; Pinto 2004: 339).

Villagers have grasped the hollowness of government claims to be concerned about people like them. But the legitimacy of the health care market is ambiguous, partial, and contested too. Both are riddled with systemic incapacities. Neither the state nor the market can guarantee a functioning referral system for obstetric emergencies (or, indeed, other health problems requiring solution beyond the primary health care level). Based on their work in West

Bengal, Bihar and Jharkhand, Corbridge et al. argue that Employment Assurance Schemes and primary education open up some spaces of empowerment for the poor in their dealings with the state (Corbridge et al. 2005: 219, 246-9). In the field of health care, however, contemporaneous changes—reductions in state provision, expansion of non-state provision—have worked to disempower the rural poor, whilst also widening income-generating opportunities for some members of the urban professional classes. In effect, poor villagers have rights neither in the state nor in the market. Sadly, despite the iconic status of maternal mortality, ongoing changes in the economy and the state provide little prospect of ameliorating the birthing experiences of women in rural UP—and rural women experiencing obstetric emergencies remain caught between a moribund state and a rapacious market that is readily accessible only to those who can pay.

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